Clinical Policy: Aliskiren (Tekturna), Aliskiren/HCTZ (Tekturna HCT)
Reference Number: CP.CPA.07
Effective Date: 11.16.16
Last Review Date: 08.18
Line of Business: Commercial

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The following are renin inhibitors requiring prior authorization: Aliskiren (Tekturna®) and Aliskiren/HCTZ (Tekturna HCT®).

FDA Approved Indication(s)
Tekturna is indicated for the treatment of hypertension in adults and children 6 years of age and older to lower blood pressure.

Tekturna HCT is indicated for the treatment of hypertension to lower blood pressure:
• In patients not adequately controlled with monotherapy
• As initial therapy in patients likely to need multiple drugs to achieve their blood pressure goals

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Tekturna and Tekturna HCT are medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Hypertension (must meet all):
      1. Diagnosis of hypertension;
      2. Age is one of the following (a or b):
         a. Tekturna: ≥ 6 years;
         b. Tekturna HCT: ≥ 18 years;
      3. Failure of a trial of an ARB or ARB combination product (e.g., olmesartan, olmesartan/hctz, irbesartan, losartan, candesartan, telmisartan, valsartan) at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;
      4. Dose does not exceed the following (a or b):
         a. Tekturna: 300 mg/day
         b. Tekturna HCT: 300/25 mg/day.

   Approval duration: Length of Benefit

B. Other diagnoses/indications
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial.

II. Continued Therapy
A. Hypertension (must meet all):
   1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   2. Member is responding positively to therapy;
   3. If request is for a dose increase, new dose does not exceed the following (a or b):
      a. Tekturna: 300 mg/day;
      b. Tekturna HCT: 300/25 mg/day.

Approval duration: Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2):
   1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
      Approval duration: Duration of request or 12 months (whichever is less); or
   2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial.

III. Diagnoses/Indications for which coverage is NOT authorized:
   A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
ACE: angiotensin converting enzyme  
ARB: angiotensin receptor blockers  
AHFS DI: American Hospital Formulary Service Drug Information  
FDA: Food and Drug Administration  
HCTZ: hydrochlorothiazide  
LVEF: left ventricular ejection fraction  
RAS: renin-angiotensin system

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>olmesartan/hctz (Benicar HCT®)</td>
<td>20/12.5 mg day</td>
<td>40/25 mg/day</td>
</tr>
<tr>
<td>olmesartan (Benicar®)</td>
<td>20 mg daily</td>
<td>40 mg/day</td>
</tr>
<tr>
<td>irbesartan (Avapro®)</td>
<td>15-300 mg daily</td>
<td>300 mg/day</td>
</tr>
<tr>
<td>losartan (Cozaar®)</td>
<td>25-100 mg daily</td>
<td>100 mg/day</td>
</tr>
<tr>
<td>candesartan (Atacand®)</td>
<td>8-32 mg daily</td>
<td>32 mg/day</td>
</tr>
<tr>
<td>telmisartan (Micardis®)</td>
<td>40-80 mg daily</td>
<td>80 mg/day</td>
</tr>
</tbody>
</table>

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### Appendix C: Contraindications

Not applicable

### Appendix D: General Information

- Dual blockade of the renin-angiotensin system (RAS) with ARBs, angiotensin converting enzyme (ACE) inhibitors, or aliskiren is associated with increased risks of hypotension, hyperkalemia, and changes in renal function (including acute renal failure) compared to monotherapy.
- According to the American Hospital Formulary Service Drug Information database (AHFS DI), ARBs have been shown to slow the rate of progression of renal disease in patients with diabetes mellitus and persistent albuminuria, and use of ARBs is recommended in patients with modestly elevated (30–300 mg/24 hours) or higher (exceeding 300 mg/24 hours) levels of urinary albumin excretion.
- The 2013 ACCF/AHA practice guideline for the management of heart failure recommend ACE inhibitors as the preferred drugs for inhibition of the renin-angiotensin system in patients with heart failure and reduced left ventricular ejection fraction (LVEF); however, ARBs may be used as an alternative in patients who are unable to tolerate ACE-inhibitors.

### V. Dosage and Administration

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>valsartan (Diovan®)</td>
<td>80-320 mg daily</td>
<td>320 mg/day</td>
</tr>
</tbody>
</table>

**Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.**

### VI. Product Availability

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aliskiren (Tekturna)</td>
<td>Tablets: 150, 300 mg</td>
</tr>
<tr>
<td>Aliskiren/HCTZ (Tekturna HCT)</td>
<td>150/12.5, 150/25, 300/12.5, 300/25 mg</td>
</tr>
</tbody>
</table>

### VII. References

5. 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults:


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3Q 2018 annual review: policy split from CP.CPA.15 into individual Tekturna policy; no significant changes; added age per FDA; references reviewed and updated.</td>
<td>04.20.18</td>
<td>08.18</td>
</tr>
</tbody>
</table>

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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